DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10112 (01/03) (Formerly DES 3071)

STATE OF WISCONSIN
WI Stats. s. 49.45

MEDICAID – DISABILITY APPLICATION

INSTRUCTIONS: This form needs to be completed by county/tribal agencies for initial application and re-applications for persons who require a disability determination in the Medicaid application process. If this form is being completed by an authorized representative complete Part VII of this application. Disability determinations are made by the Disability Determination Bureau. Do not use this form for reconsiderations/fair hearings or re-determination cases.

Providing or applying for a SSN is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to WI Stats. s. 49.82(2). SSN information will be used for administration of the Medicaid program. An applicant's SSN permits a computer check of applicant's information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Department of Workforce Development. In addition, the Department will match the applicant's name and SSN with information provided by health insurance carriers to determine if the applicant has other health insurance. The applicant's SSN will not be shared with the Immigration and Naturalization Service (INS).

Applicant Name (Last, First, MI)	Social Security Number	Birthdate	Age	Sex ☐Female ☐Male
Address (Street, City, State, Zip Code)			Agency	
Telephone Number ( )	If Applicant is Married, Name of Spouse (Last, First, MI)		Application Date	

PART I - DISABILITY INFORMATION

1. What is the disability?

2. When did the disability first prevent the applicant from working?

3. How does the disability affect the applicant's ability to perform normal daily activities?

4. Has the applicant applied for Social Security Disability (SSD) or Supplemental Security Income (SSI) benefits? (Please check box)

☐ Yes ☐ No If yes, on what date was the most recent application filed? _____

At which Social Security office (Street Address, City, State, Zip Code)?

Was the claim: ☐ Allowed ☐ Denied ☐ Still pending

PART II – MEDICAL RECORDS INFORMATION

5a. List the name, address, and telephone number of the doctor and clinic who has the most recent medical records about the applicant's disability. (If you need more space list additional doctor's and clinic's information in 5b.)

Name of Doctor (Last, First, MI)	Business Telephone Number (include area code)
Business Address (Street, City, State, Zip Code)	
Clinic Name	How often did the applicant see this doctor?
Date the applicant first saw this doctor? (mm/dd/yy)	Date the applicant last saw this doctor? (mm/dd/yy)
Reason for the applicant's visits?	
Type of treatment, surgery, or medicines received:	

5b. List the name, address, and telephone numbers of any other doctors and clinics the applicant has seen within the last two years for the disabling condition. (If you need more space go to the Additional Information Section on page 7.)

Name of Doctor (Last, First, MI)	Business Telephone Number (include area code)
Business Address (Street, City, State, Zip Code)	
Clinic Name	How often does the applicant see this doctor?
Date the applicant first saw this doctor? (mm/dd/yy)	Date the applicant last saw this doctor? (mm/dd/yy)
Reason for the doctor visits?	
Type of treatment, surgery, or medicines received:	

5b. Continued

Name of Doctor (Last, First, MI)	Business Telephone Number (include area code)

Business Address (Street, City, State, Zip Code)

Clinic Name	How often does the applicant see this doctor?
Date the applicant first saw this doctor? (mm/dd/yy)	Date the applicant last saw this doctor? (mm/dd/yy)

Reason for the doctor visits?

Type of treatment, surgery, or medicines received:

6a. Has the applicant been treated at a hospital for this disability within the past two years?

☐ Yes ☐ No If yes, list details of the most recent hospitalization below:

Name of Hospital	Patient Number

Address (Street, City, State, Zip Code)

Was the applicant an inpatient (stayed at least overnight?) ☐ Yes ☐ No	Date of Admission (mm/dd/yy)	Date of Discharge (mm/dd/yy)
Was the applicant an outpatient? ☐ Yes ☐ No	Dates of outpatient visits (mm/dd/yy)	

Reason for the applicant's hospitalization visits?

Type of treatment, or medicines received (such as surgery, chemotherapy, radiation)

6b. If the applicant has been in any other hospital within the past two years for the disability, identify it below. (If you need more space, go to Additional Information Section on page 7.)

Name of Hospital	Patient Number

Address (Street, City, State. Zip Code)

Was the applicant an inpatient (stayed at least overnight?) ☐ Yes ☐ No	Date of Admission (mm/dd/yy)	Date of Discharge (mm/dd/yy)
Was the applicant an outpatient? ☐ Yes ☐ No	Dates of outpatient visits (mm/dd/yy)	

Reason for the hospitalization visits?

Type of treatment, or medicines received (such as surgery, chemotherapy, radiation).

7. Has the applicant had any of the following tests in the past year?

TESTS		DATE COMPLETED	TEST LOCATION
Electrocardiogram (EKG) or Treadmill (Exercise)	☐ Yes ☐ No		
Echocardiogram or Cardiac Catherization	☐ Yes ☐ No		
MRI/ X-ray/CT Scan Name body part:	☐ Yes ☐ No		
Breathing Tests	☐ Yes ☐ No		
Blood Tests	☐ Yes ☐ No		
Other Tests Specify:	☐ Yes ☐ No		

8. Has the applicant been seen by other agencies for the disabling condition? (For example, Veterans Administration, Worker's Compensation, Vocational Rehabilitation, Social Service Agencies, Probation or Parole, etc.)

☐ Yes ☐ No If yes, provide the following information:

Name of Agency	Claim Number

Address (Street, City, State, Zip Code)

Dates of Visits (mm/dd/yy)

Type of treatment, exam, medicine, or services received:

9a. Information about the applicant's activities.

Has the applicant's doctor told the applicant to cut back or limit activities in any way? ☐ Yes ☐ No

If yes, give the name of the doctor below and doctor's instructions about cutting back or limiting activities.

9b. Describe the applicant's daily activities in the following areas and state what, how much, and how often each is done.

Household Maintenance (include cooking, cleaning, shopping, and odd jobs around the house as well as similar activities).

Recreational Activities and Hobbies (hunting, fishing, bowling, hiking, musical activities, etc.).

Social Contact (visits with friends, relatives, neighbors).

Other (drive a car or motorcycle, ride bus, etc.).

PART III – EDUCATION INFORMATION

10. Education Information

What is the highest grade level the applicant completed?	Has the applicant attended trade / vocational school or had any other training? ☐ Yes ☐ No If yes, complete the following:

Type of trade or vocational schooling or training?

Approximate dates the applicant attended (mm/dd/yy).

PART IV – WORK HISTORY

11. Work History

Is the applicant currently working? ☐ Yes ☐ No If yes, complete the following.

Name of Employer

Address (Street, City, State, Zip Code)

Date Started (mm/dd/yy)	Hours per Week	Rate of Pay ($ per hour)

12a. List all jobs the applicant has had within the last 15 years beginning with the most current job or the most recent job:

JOB TITLE	NAME OF EMPLOYER/TYPE OF BUSINESS	DATES WORKED From	To	HOURS PER WEEK	RATE OF PAY

12b. Complete sections 12b., 12c., 12d., 12e., 12f., and 12g. using the information from the job the applicant held the longest within the last 15 years.

In the job that the applicant held the longest within the last 15 years did the applicant:

Use machines, tools, or equipment of any kind?	☐ Yes	☐ No
Use technical knowledge or skills?	☐ Yes	☐ No
Do any writing, complete reports, or perform similar duties?	☐ Yes	☐ No
Have supervisory responsibilities?	☐ Yes	☐ No

12c. What were job duties in the job that the applicant held the longest within the last 15 years?

12d. In the job that the applicant held the longest within the last 15 years, how many total hours each day did the applicant:

Activity	Hours	Activity	Hours
Walk?		Kneel (bend legs to rest on knees)	
Stand?		Crouch? (bend legs and back down and forward)	
Sit?		Crawl? (move on hands and knees)	
Climb?		Handle, grab or grasp big objects?	
Stoop? (bend down & forward at waist)		Write, type or handle small objects?	

12e. Lifting and Carrying (Explain what the applicant lifted in this job, how far it was carried, and how often it was lifted.)

12f. Check heaviest weight lifted in this job:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____(enter amount here)

12g. Check weight frequently lifted in this job (by frequently, we mean from 1/3 to 2/3 of the workday.)

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____(enter amount here)

PART V – ADDITIONAL INFORMATION

Use this section for additional space to answer any previous question. Also use this space to give any additional information that you think will be helpful in making a decision about the applicant's Medicaid claim (such as information about other illnesses or injuries not shown, information about additional doctors seen or places or dates of hospitalizations). Refer to previous items by section number when responding.

PART VI – SIGNATURE

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The applicant's signature must be witnessed by two people if signed with an "x".)

SIGNATURE – Applicant or Authorized Representative	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

PART VII – AUTHORIZATION OF REPRESENTATIVE

This section must be completed by the person who completed this Medicaid Disability application on behalf of an applicant. Documentation must be provided to the applicant's local county/tribal social or human services department.

Did you complete a Medicaid Disability application on behalf of another person and are you that person's court appointed guardian, conservator or have durable power of attorney for health care for that person?

☐ Yes ☐ No

If you answered "Yes", stop here. You must submit, to the local county/tribal social or human services department, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid Disability application for another person?

☐ Yes ☐ No

If you are an Authorized Representative, then you and the applicant must complete the information below. Also, both you and the applicant must sign the Signature Section of this application. Also, both you and the applicant must sign this form in order for you to be an authorized representative.

Name - Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____ (name of representative) to represent me in my Medicaid Disability Application to be filed with the county/tribal human or social services department administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my disability determination. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to $25,000, imprisoned up to seven years and six months, or both and suspended from Wisconsin Medicaid (NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".)

SIGNATURE – Applicant / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

As an authorized representative I understand that I am representing the above named applicant for Medicaid Disability determination and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed

PART VIII - OFFICE USE ONLY

INFORMATION TO BE COMPLETED BY THE INTERVIEWER. THE INTERVIEWER SHOULD BE A SUPPORTIVE SERVICES PLANNER OR SOCIAL WORKER.

Does the applicant need assistance processing this claim? ☐ Yes ☐ No

If yes, list name, address, and telephone number of the person who will assist the applicant:

Name (Last, First, MI)	Relationship
Address (Street, City, State, Zip Code)	Telephone Number

Can the applicant speak English? ☐ Yes ☐ No	If applicant cannot speak English, what language can the applicant speak?
Can the applicant read English? ☐ Yes ☐ No	Can the applicant write in English (Other than his/her name)? ☐ Yes ☐ No

If the applicant cannot speak English list the name of someone that may be contacted who speaks English and will give the applicant messages:

Name (Last, First, MI)	Relationship to Applicant
Address (Street, City, State, Zip Code)	Daytime Telephone Number

Describe the applicant fully (e.g. general build, height, weight, behavior, grooming and any problems with the ability to read, write, answer, hear, sit, understand, use hands, breathe, see or walk.)

Print Name - Interviewer	Title of Interviewer
SIGNATURE - Interviewer	Date Signed
Office Address (Street, City, State, Zip Code)	Telephone Number